



Date

Eligibility Specialist
Office Address, Area Code and Telephone No.

(Name and Address of Applicant, Recipient or Responsible Person)

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Name	Individual's No.
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Your countable resource(s) and their countable equity value(s) are listed below. You have a Long-Term Care Partnership (LTCP) disregard balance available to you in the amount of \$____. Please select (by checking the box in the Yes column) from the list below the resource(s) you want to designate for the LTCP disregard and fill in the amount you want to designate in the applicable Amount Designated box, not to exceed the LTCP disregard balance available.

Note: Once a countable resource is designated you will not be able to change your mind and exchange it for another at a later date. A designated countable resource(s) must be designated in its entirety, if possible. If you dispose of the LTCP designated resource(s) you are not allowed to designate another countable resource in its place.

Yes	Countable Resource	Equity Value	Amount Designated	Name/Address/Location
<input type="checkbox"/>	Checking Account			
	Account No.	\$	\$	
	Account No.	\$	\$	
<input type="checkbox"/>	Savings Accounts, Certificates of Deposit, Individual Retirement Accounts			
	Account No.	\$	\$	
	Account No.	\$	\$	
<input type="checkbox"/>	Trust Funds	\$	\$	
<input type="checkbox"/>	Cash	\$	\$	
<input type="checkbox"/>	Land, Lots or Houses	\$	\$	
<input type="checkbox"/>	Life Insurance			
	Policy No.	\$	\$	
	Policy No.	\$	\$	
<input type="checkbox"/>	Annuities – Describe			
		\$	\$	
		\$	\$	

Yes	Countable Resource	Equity Value	Amount Designated	Name/Address/Location
<input type="checkbox"/>	Oil, Gas, Mineral, Surface Rights – Describe	\$	\$	
		\$	\$	
<input type="checkbox"/>	Life Estate	\$	\$	
<input type="checkbox"/>	Other – Describe	\$	\$	
		\$	\$	

Name of Person Completing Form (if not individual)	Relationship to Individual	Home Area Code and Telephone No.	Work Area Code and Telephone No.
Address (Street, City, State, ZIP Code)			

Be Sure This Form is Signed Before it is Returned

Signature–Individual	Date	Signature–Spouse	Date
Signature–Responsible Person	Date	Relationship to Individual	

If the individual cannot sign his name, two witnesses to the individual making his mark (X) must sign below:

Signature–Witness	Date	Signature–Witness	Date
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With a few exceptions, you have the right to request and be informed about the information that the Health and Human Services Commission (HHSC) obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local HHSC office.